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Incarcerating Individuals with Mental Health Illness in the United States

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Incarcerating Individuals with Mental Health Illness in the United States

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Abstract

This study examined empirically-based studies regarding incarcerating individuals with mental health illness in the United States (U.S.) as a form of treatment intervention. Initially, the search for studies on the topic produced 2,715 results, closer examination of those studies reduced that number to 137 journals, abstracts, and sources. Further examination concluded that only 37 of those studies met the criteria for this examination. Many of the studies that were reviewed involved interventions which occurred after release from psychiatric hospitals. Based on the findings, the most referenced estimates of mental illness in correctional facilities is attributed to Paula M. Ditton's 1999 Bureau of Justice Statistics report, which indicated, "in 1998, of the 283,800 mentally ill offenders who were incarcerated in the United States, 16% of state inmates, 7% federal inmates, and 16% of those in local jails who identified as being mentally ill,16%, or an estimated 547,800 reported that they had been hospitalized for mental illness in their lifetime (Ditton, 1999, p. 1). Although social workers in the United States "play a key role in educating the public about mental illness, in order to foster prevention" (Reichert, 2011, p. 162), they have not yet made the connection between how human rights, social justice, and social work values and ethics are all related to the population who are incarcerated. This investigation illustrates that, social workers in the United States have not fully incorporated human rights into social work practice (Reichert, 2011, p. 8). Social work professionals need to produce better research data and policy recommendations to reduce the number of incarcerated mentally ill individuals and provide them with quality medical and social service treatment options.

Key terms

Evidence-based practices, social work, stigma, mental health illness, social justice, transinstitutionalization, incarceration.

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Introduction

From the inception, the social work field has been the steward of marginalized individuals, including persons with mental illness in matters such as advocacy, intervention, assessment, and treatment. Therefore, the idea of incarcerating individuals with mental illness should be of particular concern to social work researchers. According to the Council on Social Work Education (CSWE) Educational Policy and Accreditation Standards (EPAS) competency 4, it is the duty of social work professionals to "engage in practice-informed research and research-informed practice" (Council on Social Work Education, 2017, p. 8). Therefore, the aim of this study is to assess the effectiveness of treatment, or lack thereof, which is currently being delivered to persons with mental illness in correctional facilities in the United States from a social work approach. By understanding the history of mental illness in the United States, researchers can better determine how problems with previous treatment methods might correlate with current treatment issues. By looking at this matter from a holistic perspective, researchers establish how incarcerating individuals with mental illness plays a key role in the persistence of mental illness.

This literature review assesses, 1. what research is still needed; 2. what types of policies need to be enacted; 3. what type of treatment model is best suited for this population; and 4. within what type of setting. By taking a holistic approach, social workers, educators, health care professionals, and those who work directly with this population can begin to draft more effective policy proposals that ensure more appropriate measures of treatment can be delivered to mentally ill individuals who have also been criminally convicted and sentenced to local or state correctional facilities. From a generalist social work perspective, it has been a practice of the profession, not to merely concentrate on issues

surrounding the social functioning ability of the individuals that they serve, but also on the social functioning of the systems and institutions within that individual's environment (Johnson & Yanca, 2010, p. 13). In doing so, social workers can begin to draft more effective policy proposals that will ensure that appropriate treatment is delivered to incarcerated mentally ill persons and initiate steps to have these individuals removed from the criminal justice system.

Methods

Research data was examined for inclusion in this study based on its historic and current relevance to mental health treatment methods. Materials included, *The Journal of the Society of Architectural Historians, The Journal of Psychiatry & Law, American Journal of Public Health, Journal of Health and Social Behavior, New England Journal of Medicine, American Bar Association Journal, American Journal of Psychiatry,* Sociology Abstracts, and Public Access to Court Electronic Records (PACER).

Topic Description and Justification

Mental health illness includes any person who struggles with mild, moderate, or serious mental disease. In the United States, 18.29% or 43.7 million adults suffer with some degree of mental illness. In New York, 17.67% or 710,000 adults were found to have varying degrees of mental health illness. In 2011, 59% of adults who suffered from some form of mental health problem "did not receive any mental health treatment" (Mental Health America, n.d.). From a social work perspective, these statistics are a concern, and justify research and advocacy on the social justice issues involved in the failed treatment of the millions of human beings who are currently confined in criminal correctional facilities.

As public mental health treatment facilities in the United States continue to lose programs and funding, millions of mentally ill individuals continue to experience the consequences of this failed system. Consequences of which can be seen in communities across the nation, where the results of untreated mental health patients, often, has led to police contact (Treatment Advocacy Center, n.d.). These former patients are now in the hands of the criminal justice system that has, for decades, been tasked with controlling individuals with mental illness. Because jails and prisons are unequipped for the task of effectively providing treatment to the mentally ill inmates in their custody, these inmates typically end up in segregated cells (Slate, 2013, p. 492). Ultimately these individuals are released from prison and into the same broken system that failed them in the first place.

The concept of institutionalizing individuals with mental illness is not a remedy to a failed system. In fact, history shows us that individuals with mental illness have been subjected to some of the most unspeakable cruelty throughout the course of civilized society. Today, society continues to use confinement as its default approach to care.

A Brief History of Mental Health Treatment

The idea of incarcerating individuals with mental illness as a form of treatment, anecdote, or social solution can be dated back as far as 1685, the Age of Reason, or Enlightenment, when it was common to be imprisoned and put to death as a form of "social control" (McLynn, 1989; Slate, 2013). Slate suggests that hospitals were reported to have been "with no sanitation measures in place, patients chained to the walls, tortured, and left screaming in the darkness and squalor under the premise that it was therapeutic" (Slate, 2013, p. 22).

It was not until the late 18th century that the first revolution in the care of the mentally disordered began with the work of French physician Philippe Pinel, who is credited by some as the father of mental health morality. In fact, in 1791, Pinel is also said to be the first person to declare that putting individuals with mental illness in chains was not only inhumane, but immoral (Slovenko, 2012, p. 136). This moral concern grew in the United States when, "affluent members of society were found visiting psychiatric hospitals to witness what is described as "picturesque delusions" (Stevens, 1996, p. 254; Slate, 1013, p. 22).

During the 19th century the focus began to be placed on effective treatment of mental illness. However, in the 1840s, American activist and social reformer Dorothea Dix (1802-1187) reported to the North Carolina General Assembly incidents she observed where the mentally ill had been "chained to their beds, kept in filthy conditions, and even abused" (Ghareeb, n.d.; History of Mental Health Treatment, n.d.; Slate, 2013). In 1842, because the purpose of psychiatric facilities had shifted primarily to warehousing individuals in the United States, New York implemented a law which "called for the "confinement of all "lunatic[s]" in the community" (Slate 2013, p. 24). According to Slate (2013), "the individuals presented by the assessors received little to no procedural justice prior to being committed to the asylum and often endured this blight on their civil liberties for the rest of their life" (p. 24).

By the 20th century Clifford Beers had introduced the Mental Hygiene Movement, which paved the way to founding the National Mental Health Association, now referred to as Mental Health America (DiNitto & Johnson, 2016, p. 400). It was during this era that psychiatric hospitals began to emerge all over the country. This institutional approach of displacement is said to have served as an "out of sight out of mind" method of treatment. (History of Mental Health Treatment, n.d.). The

institutional model, however, meant that mental illness was now viewed from a medical perspective and was considered an illness (Unite for Sight, n.d., para 4). This approach served to increase patient access to care, however, the cost of that care and the enormity of individuals who were declared mentally ill began to far outweigh any considerations of care. Because of this, psychiatric hospitals increasingly faced criticisms regarding poor living conditions, human rights violations, and abuse (History of Mental Health Treatment, n.d.).

Approaches to mental health treatment shifted again in 1946, when President Harry Truman signed the National Mental Health Act (NMHA), which called for "the establishment of a National Institute of Mental Health." (NMHA, 1946). This Act was, in part, due to the number of men who, during World War II, were "discharged for psychiatric reasons" (DiNitto & Johnson, 2016, p. 400). Another reason why Truman felt compelled to sign the Act was because of the outrage in which Americans had viewed the 1948 movie *The Snake Pit*, a true story about Mary Jane Ward's experience as a patient in a psychiatric hospital. The movie conceptualized the terror and horror that Ward ascribes to her experience (Slate, 2013, p. 31). Although the NMHA reportedly called for a "cure" for mental illness, it would not be until the 1950s that a drug was introduced as a potential cure. Chlorpromazine, under the brand name Thorazine, which was "synthesized in December 1951 in the laboratories of Rhône-Poiulenc, became available on prescription in France in November 1952" (Ban, 2007, p. 495). Psychiatrist, Thomas A. Ban, explains that, "until the 1950s there was no such scientific discipline as psychopharmacology and there was no effective drug therapy for mental illness" (p. 495).

By the 1950s and 1960s, the deinstitutionalization of psychiatric facilities began its first phase due to medications like Chlorpromazine. During the first eight months, over two million patients were

being prescribed Chlorpromazine, and over the next ten years, reports indicate that more than fifty million individuals, worldwide had been prescribed Chlorpromazine as a cure for mental illness (Slate, 2013, p. 31; Early 2006). Deinstitutionalization from psychiatric facilities was intended to relocate patients from psychiatric facilities to a more suitable outpatient status on the premise that psychotherapeutic medications in the United States "reduced many of the troubling symptoms (such as hallucinations) that patients experienced" (DiNitto & Johnson, 2016, p. 401). Researchers argue that releasing millions of patients who had been prescribed Chlorpromazine, as a "cure" for mental illness, helped to ignite what would later become the dissension of the medical model of treatment and the ascension of legalized criminalization of individuals with mental illness. Chlorpromazine became the "miracle drug" according to psychiatrists who prescribed it. According to Slate (2013), for its inventor, Smith Kline, whose revenues doubled three times in in the first 15 years, Chlorpromazine was the wonder drug (p. 31). It was also during this period that the Mental Health Study Act of 1955 (Public Law 84-182) called for "an objective, thorough, nationwide analysis and reevaluation of the human and economic problems of mental health" (National Institute of Mental Health, 2017, para. 9). This Act, under President Eisenhower, called for a "systematic examination of the issue on a national level (Slate, 2013, p. 37).

In the 1960s, the use of psychotherapeutic drugs played a pivotal role in establishing the framework for the Mental Retardation Facilities and Community Mental Health Centers Construction Act (CMHC) of 1963 (DiNitto & Johnson, 2016, p. 401). As a part of CMHC, "community mental health centers were required to provide five essential services: inpatient care, outpatient care, emergency services, partial hospitalization, and consultation and education" (DiNitto & Johnson, 2016, p. 401). That same year, Psychiatrists Michel Foucault, R.D. Laing, and Thomas Szasz established the anti-psychiatry movement, sparked by R.D. Laing's (1960) argument that "mental

illness was purely due to social causes and, in so doing, implied that mental illness could be eradicated through social remedies" (Slate, 2013, p. 37). Later that year, civil rights attorney and physician Morton Birnbaum conceptualized the idea of a Constitutional right to treatment (p. 502). In Birnbaum's thesis entitled, *The Right to Treatment* (1960), he argued that, mental health treatment was a Constitutional right. However, the idea was not only rejected by his peers in the legal profession, the medical community rejected him as well, refusing to even consider his proposal. Birnbaum's position was that, without the provision of treatment and regulatory standards in place to manage that treatment, the needs of those who had been hospitalized against their will could not be considered patients and that psychiatric hospitals were no more than a "mental prison" (1960, p. 503; Slate, 3013, p. 35).

In 1966, Birnbaum's concept of a constitutional right to treatment was challenged when, Judge David L. Bazelon, granted an appeal in the 1962 case of, *Rouse v. Cameron*, based on the argument of whether a person who has been acquitted of a crime and involuntarily placed in a mental institution based on Not Guilty by Reason of Insanity (NGRI) has the right to treatment. In his ruling, Judge Bazelon, agreed with Birnbaum's assertion that the absence of treatment made psychiatric hospitals no more than a penitentiary (*Rouse v. Cameron*, 1966; Slate, 2013, 35). Birnbaum's thesis was further conceptualized by Judge Bazelon's decision, which stated that mental health treatment should be prescribed "in the least restrictive setting possible, specifying that treatment should be done in the community or with family members whenever feasible" (Judge David L. Bazelon Center for Mental Health Law, 2012b).

The process of deinstitutionalization consisted of a three-step plan which included, establishing community programs that would receive patients being discharged randomly into

communities; discharging patients into those established programs, and; community treatment options for those who would, otherwise, be committed to psychiatric hospitals prior to community mental health services. (Slate, 2013, p. 38). By the 1970s, however, this process had begun to show its faults. Many of the shortcomings within the deinstitutionalization process became more apparent when reports began to surface showing that "deinstitutionalization had simply become "transinstitutionalization" a phenomenon in which state psychiatric hospitals and criminal justice systems are "functionally interdependent" (Knapp, et al., 2010). Hence, while the mental health condition of thousands of newly released patients began to decline, the population of local and state correctional facilities across the country began to swell. According to reports, "since the 1970s, a rapid rise in the nation's prison population has directly corresponded with a sharp decline in the number of Americans institutionalized at mental health hospitals" (Culp-Ressler, 2013, para. 2). (See Appendix A).

Dr. Christine Montross, who works in an intensive treatment unit of a psychiatric hospital reported that, many times when a psychiatric patient has intersected with the criminal justice system it is because their care providers are overwhelmed and are seeking some form of public relief. Research shows that this type of respite is also sought by the community at large. Studies show that the deinstitutionalization of psychiatric hospitals during the 70s and 80s played a central role in today's penal methods of confinement (2016, p.1407; Rich, n.d.). Montross, who also performs court-ordered psychiatric examinations, says that outcomes for the patients she treats in the hospital setting are drastically different from the outcomes of those who are confined to prison. She argues that, once the criminal justice system becomes involved "the decision about whether that person belongs in jail or in the hospital is rarely a clinical one. Instead, it's made by

the gatekeepers of the legal system: police officers, prosecutors, and judges" (Montross, 2016, p. 1407).

Ultimately, society's treatment of its mentally ill has led to multiple layers of stigma. Researchers, have defined stigma as "an attribute, behavior, or reputation that is socially discrediting" (Slate, 2013; Goffman, 2016; Becker; 1963). Once patients were nearly completely discharged from psychiatric care, the "out of sight, out of mind" invisibility cloak was removed, the general reaction from the public was fear. Research demonstrates that, between 1950 and 2000, the number of people who believed that "people with mental illness are dangerous, violent, and/or frightening increased by 250%" (Phelan, et al. 2000).

The Results of Treatment Throughout history is Stigma

As dictated by history, once society is able to rationalize its views of individuals with mental illness, it is easy to ignore the negligent standards of care that are given to individuals whose social construct has been determined based on their perceived otherness. As an integral part of the process to create this "us" versus "them" the classification system of labeling then becomes a tool in promoting a cycle of prejudice and discrimination (2013, p. 58). When looking at stigma from a macro systems perspective, researchers agree that social policies, rules, and procedures are what has helped to erect the structural limitations that impact people who are minority, gay, female, or differently abled. Researchers contend that it is these barriers that perpetuate the maltreatment of mentally ill individuals (Early, 2006; Slate, 2013).

While public fear remains, a large body of research disproves accounts that violent crimes in the United States are committed by someone who is mentally ill. In fact, studies show that most people who are identified as mentally ill will never commit a violent act (Applebaum,

et al., 2000; Swanson, et al., 2006; Slate, 2013). The impact of stigma that is associated with mental illness has only progressed since the days of Dorothea Dix, when people who suffered from mental illness were seen as "toxic waste" and our institutions as sanitation systems. (Austin & Irvin, 2012). According to research, scientific theories have made biological and physical discoveries that there are distinctions between the characteristics of someone with a mental illness or someone who has a propensity for criminal behavior, compared to someone who is scientifically "normal" (Wahl, 2006; Slate, 2013). In this way, Wahl argues that, if scientists can demonstrate to the world that there are superior and inferior human beings based on physical traits, and that these traits can be associated with deviant behavior, how are these distinctions interpreted in our social welfare policies? (2013, p. 8). According to the Council on Social Work Education (CSWE), it is the responsibility of social workers to not only understand how to interpret social welfare policies at the local, state, and federal levels, CSWE Competency 5: Engage in Policy Practice, informs social workers that they should also understand how to "apply critical thinking to analyze, formulate, and advocate for policies that advance human rights and social, economic, and environmental justice" (p. 8).

The Prevalence of Mentally Ill Individuals in Correctional Facilities

Based on a research survey on the population size of jails and prisons in the United States over the past 25 years, the number of incarcerated individuals has quadrupled (Wilper et al., 2009, p. 666). The United States has 750 incarcerated individuals per 100,000 global inhabitants. Indias has 30, Norway has 75, China has 119, the United Kingdom has 148, and Russia has 628, (Wilper et al., 2009, p. 666).

Seth J. Prins (2014), suggests that the prevalence of individuals with mental illness in the criminal justice system in the United States far outweighs that of non-mentally ill individuals (p.

862). Although this topic continues to get attention from researchers, lawmakers, and advocates, trying to get accurate estimates remains problematic because many of the study's findings consists of mission statements and program proposals instead of the more reliable estimates that are needed to "plan and implement policy and programmatic responses" (Prins, 2014, p. 862). In the meantime, social workers, policymakers, researchers, and law officials are trying to prove that correctional facilities are not designed to treat severely mentally ill individuals.

Incarcerating Individuals with Mental Health Illness in the United States

The 21st century solution to the mental health crisis in the United States became even more apparent to researchers when the role of police officers shifted from serve and protect to removing mentally ill individuals from public spaces. These people are caught in the crossfire of two different institutions: the mental health system and the criminal justice system. As is the case with levels of government, the bigger system won. In 2001, treatment advocates sparked public interest in the moral treatment of incarcerated mentally ill individuals when a class-action lawsuit was filed on behalf of Marciano Plata and others that claimed California's State Correctional Department had violated the Eighth Amendment to the Constitution, which bans "cruel and unusual punishment" (*Brown v. Plata, 2010*). The lawsuit argued that the state had failed to provide adequate medical care. After a lengthy trial, the court decided that overcrowding was the "primary cause" for violations in California's 33 prisons and ordered the release of 38,000 to 46,000 inmates. However, even after the court made its decision, California's Correction Department still refused to comply. After orders from the district court were not met, this case went before the Supreme Court to remedy. The Supreme Court ultimately upheld the decision agreeing that massive overcrowding in California's 33 prisons was a violation of the Eighth Amendment rights of prisoners (*BROWN v. PLATA*, 2010). At the time of the court's decision California's prisons, which were designed to house 85,000 inmates, were found to be

housing 156,000 prisoners, twice its capacity (Newman & Scott, 2012, p. 13), further increasing its inability to effectively care for its mentally ill population.

Community mental health programs in the United States are in crisis. The sparse programs that managed to be put in place in the community are too overwhelmed to be effective. For social work researchers and those whose charge it is to advocate for marginalized individuals that society's approach to caring for its mentally ill has turned to the criminal justice system should be of particular concern. In 2007, Anasseril E. Daniel, released a study that reported 2.2 million individuals were incarcerated in the United States, the highest rate of incarceration globally. Research points to deinstitutionalization as the leading cause (2007, p. 406). According to Daniel's report, "more than half of all prison and jail inmates have a mental health problem compared with 11 percent of the general population, yet only one in three prison inmates and one in six jail inmates receive any form of mental health treatment" (2007, p. 406). When addressing what type of treatment model is best suited for this population, and within what type of setting, Competency 9: Evaluate Practice with Individuals, Families, Groups, Organizations, and Communities, suggests that **s**ocial workers "understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge in evaluating outcomes" (CSWE, 2015, p. 9).

Discussion/Recommendations

The generalist social work practitioners in the United States who stick to the antiquated social justice approach to today's human rights problems should consider that today's social work professional must understand the varying realms of oppression that impact incarcerated individuals who are suffering with a mental illness. According to the Council on Social Work Education (CSWE), Educational Policy and Accreditation Standards (EPAS), "social workers

recognize and understand the historical, social, cultural, economic, organizational, environmental, and global influences that affect social policy. They are also knowledgeable about policy formulation, analysis, implementation, and evaluation" (p. 8).

Reichert (2011) argues that, unlike international social workers, social workers in the United States have not yet made the connection between how human rights, social justice, and social work values and ethics are all related. Reichert suggests that, the reason why social workers in the United States have not incorporated human rights into social work practice rests on three factors: first, social workers are still referring to their anachronistic theories to validate the importance that they placed on social justice. Second, social workers associate human rights with the legalities of human rights issues rather than with social justice issues. Third, even though the National Association of Social Work bears the title International Policy on Human Rights, very few social workers in the United States have fully embraced human rights, except for how it relates to social and economic justice (Reichert, 2011, p. 8-11). Whether incarcerating individuals with mental illness is a social justice or human rights concern presents several dilemmas for social work professionals with regards to the client who is not getting treatment. However, as it stands, police officers across the country are playing the roles of both social worker and psychiatrist (Slate, 2013).

One of the primary missions of the National Association of Social Workers (NASW) is to, "promote social justice and social change with and on behalf of clients" (2017, p.1). Criminalizing individuals with mental illness perpetuates the conceptualization that *all* individuals with mental illness are criminals and a probable danger to society and law enforcement. Reichert suggests that, for some social workers, the question remains about whether or not social justice is an outdated concept, she contends that, "the satisfying sound of

this term clearly helps support its continued use in the profession. But the use of the term simply because it evokes a desirable resonance is meaningless if the term itself lacks clear definition" (2011, p. 11).

Social workers should focus research and policy recommendations on more nuanced classification systems. Psychiatrists suggest when defining the term mental illness, "lumping all psychological disorders together would make it extremely difficult to understand them better. A sound classification system for mental disorders can facilitate empirical research and enhance communication among scientist and clinicians" (Weiten, 2013, p. 451). Consequently, the social model for police related responses to calls that involve mentally ill individuals need to be clarified as well, so that the criminal justice system does not lump all mentally ill prisoners into the same classification system.

There is an overwhelming representation of individuals with mental illness in the criminal justice system in the United States and solutions are needed at the local, state, and federal level. Some work has already been started. For example, in 2002 the Council of State Governments released a report that outlines the collaborative efforts of the Criminal Justice/Mental Health Consensus Project, which consisted of "state legislators, law enforcement officials, prosecutors, defense attorneys, judges, corrections administrators, community corrections officials, and victim advocates, mental health advocates, consumers, state mental health directors, and community-based providers" (2002, xiv). The 430-page report was released for public view and directed towards any local or state agency that sought to join the collaborative efforts in finding effective ways to treat incarcerated individuals with mental illness. The project involved training professionals and policymakers and educating community members and families who were caring for someone with a mental illness. The project used

evidence-based practices, “standardized treatments and services subjected to controlled research involving objective outcome measures and more than one research group” and suggested that all measures be employed in treating the varying symptoms of mental disorders that individuals experience, including “appropriate use of all available psychotropic medications; assertive community treatment; supported employment; family psychoeducation; illness self-management; and integrated treatment for co-occurring mental illness and substance abuse disorders ” (Council of State Governments, 2002, p. 250).

This multi-level approach can also set best-practices for social workers and others for varied treatment initiatives, in various settings. Beyond this, there is a pressing need for further research to determine estimates regarding the prevalence of mental illness on both a community and state level, and the short and long-term consequences of inadequate treatment delivery in U.S. correctional facilities. Increasing the quality and quantity of treatment delivery in community settings is imperative for preventing or reducing the number of individuals with mental illness that encounter the criminal justice system.

References

Appelbaum, P. S., Robbins, P. C. & Monahan, J. (2000). Violence and delusion: Data from the MacArthur Violence Risk Assessment Study. *American Journal of Psychiatry, 157(4), 566-572*.

Austin, J., & Irwin, J. (2012). *It's about time: America's imprisonment binge*. Wadsworth.

Ban, T. A. (2007). Fifty years chlorpromazine: a historical perspective. *Neuropsychiatric Disease and Treatment*, 3(4), 495-500.

Becker, H. S. (1963). *Outsiders: Studies in sociology of deviance*. New York, NY: Free Press.

Birnbaum, M. (1960) The right to treatment, *American Bar Association Journal, 46,* 499-505.

Brown v. Plata, 563 US 493 (2011). Retrieved October 22, 2016, from https://www.law.cornell.edu/supct/html/09-1233.ZS.html.

Council of State Governments. (2002). Criminal Justice/Mental Health Consensus Project. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf.

Council on Social Work Education. (2015). EPAS Handbook. Retrieved December 4, 2017, 2016, from https://www.cswe.org/getattachment/Accreditation/Accreditation-Process/2015-EPAS/2015EPAS_Web_FINAL.pdf.aspx.

Culp-Ressler, T. (2013). As Mental Health Services Have Disappeared, The Prison Population Has Skyrocketed. *Think Progress.* Retrieved from https://thinkprogress.org/as-mental-health-services-have-disappeared-the-prison-population-has-skyrocketed-3b24705f7fca/.

Daniel, A. E. (2007). Care of the Mentally Ill in Prisons: Challenges and Solutions. *The Journal of the American Academy of Psychiatry and the Law*, 35(4), 406-410.

DiNitto, D. M., & Johnson, D. H. (2016). *Social welfare politics and public policy*. Pearson.

Ditton, P. M. (1999). Special Report: Mental Health and Treatment of Inmates and Probationers. U.S. Department of Justice Office of Justice Programs. Retrieved from https://www.bjs.gov/content/pub/pdf/mhtip.pdf.

Earley, P. (2006). *Crazy: A father's search through America's mental health madness*. Berkley Books.

Goffman, E. (2016). *Asylums essays on the social situation of mental patients and other inmates*. Anchor Books, a division of Random House.

History of Mental Health Treatment. (n.d.). Retrieved June 30, 2017, from http://www.dualdiagnosis.org/mental-health-and-addiction/history/.

Johnson, L. C., & Yanca, S. J. (2010). *Social work practice: A generalist approach*. Allyn and Bacon.

Judge David L. Bazelon Center for Mental Health Law. (2012b). Who we are. Washington, D.C.: Author. Retrieved from http://www.bazelon.org/about/who-we-are/.

Knapp, M., Beecham, J., Mcdaid, D., Matosevic, T., & Smith, M. (2010, 12). The economic consequences of deinstitutionalisation of mental health services: Lessons from a systematic review of European experience. *Health & Social Care in the Community*, 19(2), 113-125.

Laing, R. D. (1960). *The divided self: An existential study in sanity and madness*. Penguin Books.

McLynn, F. (1989). *Crime and punishment in eighteenth-century England*. London, England: Routledge.

Montross, C. (2016, 10). Hard Time or Hospital Treatment? Mental Illness and the Criminal Justice System. *New England Journal of Medicine,* 375(15), 1407-1409.

National Association of Social Workers. (2017). Code of Ethics. Retrieved December 4, 2017, from https://www.socialworkers.org/LinkClick.aspx?fileticket=ms_ArtLqzeI%3D&portalid=0.

National Institute of Mental Health. (2016). Transforming the understanding and treatment of mental illnesses. Rockville, MD: Author. Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml.

Newman, W. J., & Scott, C. L. (2012, December 01). *Brown v. Plata*: Prison Overcrowding in California. *Journal of the American Academy of Psychiatry and the Law Online,* 40(4), 547-552.

Phelan, J. C., Link, B. G., Stueve, A., & Pescosolido, B. A. (2000, 06). Public Conceptions of Mental Illness in 1950 and 1996: What Is Mental Illness and is it to be feared? *Journal of Health and Social Behavior, 41*(2), 188.

Prins, S. J. (2014, 07). Prevalence of Mental Illnesses in U.S. State Prisons: A Systematic Review. *Psychiatric Services, 65*(7), 862-872.

Reichert, E. (2011). *Social work and human rights: A foundation for policy and practice*. Columbia University Press.

Rich, R. (n.d.). The Great Recession. Retrieved from https://www.federalreservehistory.org/essays/great_recession_of_200709.

Rouse v. Cameron, 373 F.2d 451 (D.C. Cir., 1966).

Slate, R. N., Buffington-Vollum, J. K., & Johnson, W. W. (2013). *The criminalization of mental illness crisis and opportunity for the justice system*. Carolina Academic Press.

Slovenko, R. (2012). Criminal Law Standards in Civil Commitment. *The Journal of Psychiatry & Law, 40*(2), 135-166.

Stevenson, C. (1996, 09). Robert Hooke's Bethlem. *Journal of the Society of Architectural Historians, 55*(3), 254-275.

Thompson, H. A. (2010, 12). Why Mass Incarceration Matters: Rethinking Crisis, Decline, and Transformation in Postwar American History. *Journal of American History, 97(3),* 703-734.

Treatment Advocacy Center. (2014). The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey. Retrieved from http://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf.

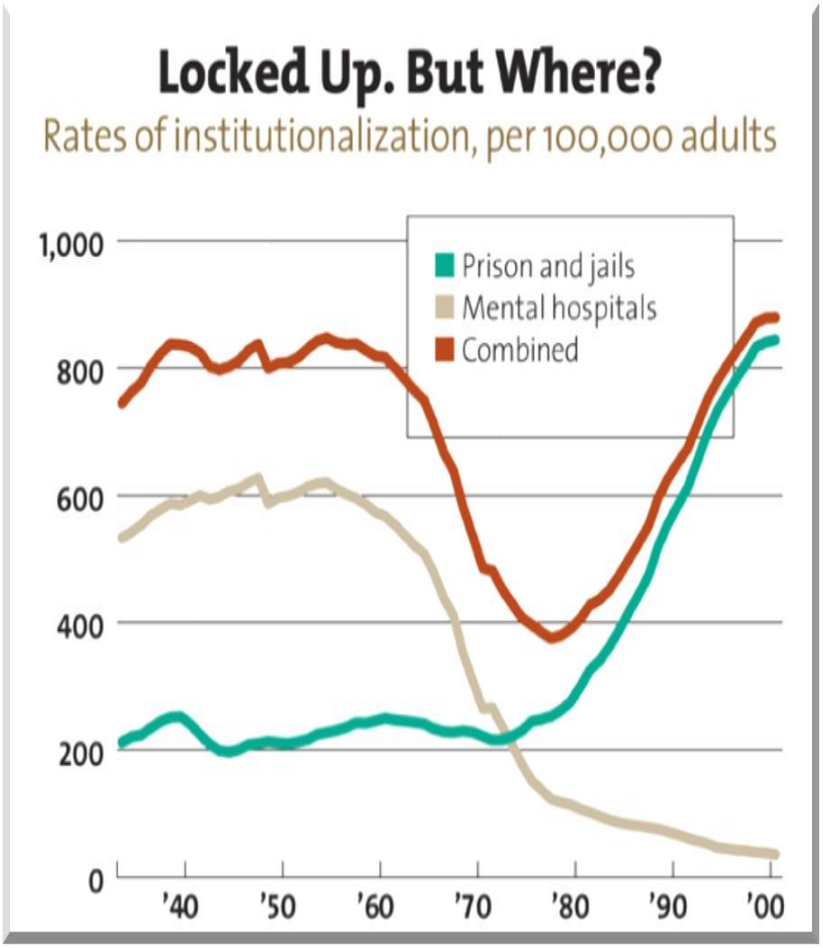
United For Sight. (n.d.). Module 2: A Brief History of Mental Illness and the U.S. Mental Health Care System. Retrieved June 20, 2017, from http://www.uniteforsight.org/mental-health/module2#_ftn3.

Wahl, O. F. (2006). *Media madness: Public images of mental illness*. Rutgers University Press.

Weiten, W. (2011). *Psychology: Themes and variations*. Wadsworth Cengage Learning.

Wilper, A.P., Woolhandler, S., Boyd, J. W., Lasser, K.E., McCormick, D., Bor, D. H., & Himmelstein, D.U. (2009). The health and health care of us prisoners: Results of a nationwide survey. *American Journal of Public Health, 99,* 666-672.

Appendix A



Source:https://thinkprogress.org/as-mental-health-services-have-disappeared-the-prison-population-has-skyrocketed-3b24705f7fca